		FOR OHF USE					

LL1

2000
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2000)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0041277

Facility Name: Alden Northmoor Rehab & HCC

Address: 5831 N. Northwest Hwy (Number) Chicago (City) 60631 (Zip Code)

County: Cook

Telephone Number: (773) 775-8080 **Fax #** (773) 775-9672

IDPA ID Number: 36-3847747

Date of Initial License for Current Owners: 03/29/96

Type of Ownership:

[ ]	VOLUNTARY,NON-PROFIT	[X]	PROPRIETARY	[ ]	GOVERNMENTAL
[ ]	Charitable Corp.	[ ]	Individual	[ ]	State
[ ]	Trust	[ ]	Partnership	[ ]	County
		[ ]	Corporation	[ ]	Other
		[X]	"Sub-S" Corp.		
		[ ]	Limited Liability Co.		
		[ ]	Trust		
		[ ]	Other		

IRS Exemption Code

In the event there are further questions about this report, please contact:
Name: Steven M. Kroll **Telephone Number:** (773) 286-3883

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/00 to 12/31/00 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) _____ (Date)

(Type or Print Name) Steven M. Kroll

(Title) Chief Financial Officer

Paid Preparer

(Signed) _____ (Date)

(Print Name and Title)

(Firm Name & Address)

(Telephone) ( ) Fax # ( )

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 **Phone # (217) 782-1630**

Facility Name & ID Number Alden Northmoor Rehab & HCC # 0041277 Report Period Beginning: 01/01/00 Ending: 12/31/00

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	198	Skilled (SNF)	198	72,468	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	198	TOTALS	198	72,468	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	4,199	3,541	8,713	16,453	8
9	SNF/PED					9
10	ICF	36,302	15,745	155	52,202	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	40,501	19,286	8,868	68,655	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 94.74%

D. How many bed-hold days during this year were paid by Public Aid?
1,530 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
None

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 03/29/96

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date Lease start 11/01/96 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 40 and days of care provided 8,360

Medicare Intermediary AdminiStar Federal Inc.

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/00 Fiscal Year: 12/31/00

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number Alden Northmoor Rehab & HCC # 0041277 **Report Period Beginning:** 01/01/00 **Ending:** 12/31/00

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	497,383	49,661		547,044	328	547,372		547,372			1
2	Food Purchase		438,430		438,430	(37,538)	400,892	(12,559)	388,333			2
3	Housekeeping	27,197	34,521	186,940	248,658	777	249,435	41,556	290,991			3
4	Laundry	83,838	39,960		123,798	87	123,885		123,885			4
5	Heat and Other Utilities			258,830	258,830		258,830		258,830			5
6	Maintenance	47,486		194,627	242,113	6,701	248,814	8,688	257,502			6
7	Other (specify):*											7
8	**TOTAL General Services**	655,904	562,572	640,397	1,858,873	(29,645)	1,829,228	37,685	1,866,913			8
	B. Health Care and Programs											
9	Medical Director			20,400	20,400		20,400		20,400			9
10	Nursing and Medical Records	2,598,236	55,342	4,057	2,657,635	2,744	2,660,379	(591)	2,659,788			10
10a	Therapy	17,635			17,635	480	18,115		18,115			10a
11	Activities	148,327	7,646	2,937	158,910	62	158,972	480	159,452			11
12	Social Services	47,979		1,030	49,009		49,009		49,009			12
13	Nurse Aide Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	2,812,177	62,988	28,424	2,903,589	3,286	2,906,875	(111)	2,906,764			16
	C. General Administration											
17	Administrative	69,033			69,033		69,033		69,033			17
18	Directors Fees											18
19	Professional Services			934,839	934,839	(480)	934,359	(864,613)	69,746			19
20	Dues, Fees, Subscriptions & Promotions			52,844	52,844	(6,260)	46,584	(33,259)	13,325			20
21	Clerical & General Office Expenses	643,568	20,505	55,239	719,312	21	719,333	94,426	813,759			21
22	Employee Benefits & Payroll Taxes			483,510	483,510	33,078	516,588	61,439	578,027			22
23	Inservice Training & Education			1,450	1,450		1,450		1,450			23
24	Travel and Seminar			762	762		762	18,482	19,244			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			697	697		697	50,472	51,169			26
27	Other (specify):*											27
28	**TOTAL General Administration**	712,601	20,505	1,529,341	2,262,447	26,359	2,288,806	(673,053)	1,615,753			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	4,180,682	646,065	2,198,162	7,024,909		7,024,909	(635,479)	6,389,430			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Alden Northmoor Rehab & HCC #0041277 Report Period Beginning: 01/01/00 Ending: 12/31/00

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			34,413	34,413		34,413	301,336	335,749			30
31	Amortization of Pre-Op. & Org.							8,009	8,009			31
32	Interest			103,834	103,834		103,834	728,405	832,239			32
33	Real Estate Taxes							442,929	442,929			33
34	Rent-Facility & Grounds			1,552,513	1,552,513		1,552,513	(1,552,513)				34
35	Rent-Equipment & Vehicles			9,177	9,177		9,177	25,335	34,512			35
36	Other (specify):* **mortg. Insur.**							54,509	54,509			36
37	**TOTAL Ownership**			1,699,937	1,699,937		1,699,937	8,010	1,707,947			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		498,736	960,674	1,459,410		1,459,410	(564,109)	895,301			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			108,702	108,702		108,702		108,702			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**		498,736	1,069,376	1,568,112		1,568,112	(564,109)	1,004,003			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	4,180,682	1,144,801	4,967,475	10,292,958		10,292,958	(1,191,578)	9,101,380			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number Alden Northmoor Rehab & HCC # 0041277 Report Period Beginning: 01/01/00 Ending: 12/31/00

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(8,939)	30		9
10	Interest and Other Investment Income	(145)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(3,600)	2		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(186)	32		18
19	Entertainment				19
20	Contributions	(250)	20		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(17,823)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising	(12,501)	20		28
29	Other-Attach Schedule				29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (43,444)		$	30

OHF USE ONLY								
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(883,334)	VARY	34
35	Other- Attach Schedule **SEE PG 5A**	(264,800)	VARY	35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (1,148,134)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (1,191,578)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		X	$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule		X			45
46	Other-Attach Schedule		X			46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

STATE OF ILLINOIS **Page 5A**

Alden Northmoor Rehab & HCC

ID# 0041277

Report Period Beginning: 01/01/00

Ending: 12/31/00

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	non-cost part b therapy c/a: gls: 5212/3/4(partial)	$ (10,644)	39	1
2	non-cost hmo nursing supply c/a: gl 5026	(12,075)	39	2
3	non-cost hmo drug c/a gl 5042	(40,788)	39	3
4	non-cost hmo oxygen c/a: 5080	(4,662)	39	4
5	non-cost: hmo therapy c/a: gl 5040	(187,765)	39	5
6	non-cost: hmo isolation c/a: gl5093	(2,800)	39	6
7	pas fees (none allowable expense)	(2,426)	20	7
8	reclass massage therapy from ln 19 to ln 11	480	11	8
9	reclass massage therapy from ln 19 to ln 11	(480)	19	9
10	community realaation	(976)	20	10
11	reclass painting>$1,500 for 2000 to pg 22 from ln 6	(5,943)	6	11
12	record deprec. Exp. On painting reclass for 2000	990	6	12
13	record deprec. Exp. On painting reclass for 1999	2,290	6	13
14				14
15				15
16				16
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89				89
90	**Total**	(264,800)		90

STATE OF ILLINOIS — Summary A

Facility Name & ID Number Alden Northmoor Rehab & HCC # 0041277 **Report Period Beginning:** 01/01/00 **Ending:** 12/31/00

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(3,600)	0	0	(8,959)	0	0	0	0	0	0	0	(12,559)	2
3	Housekeeping	0	0	0	0	0	41,556	0	0	0	0	0	41,556	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	(2,663)	0	11,351	0	0	0	0	0	0	0	0	8,688	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(6,263)	0	11,351	(8,959)	0	41,556	0	0	0	0	0	37,685	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	(591)	0	0	0	0	0	0	(591)	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	480	0	0	0	0	0	0	0	0	0	0	480	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	480	0	0	0	(591)	0	0	0	0	0	0	(111)	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(480)	5,875	(869,932)	0	0	0	0	(76)	0	0	0	(864,613)	19
20	Fees, Subscriptions & Promotions	(33,976)	0	717	0	0	0	0	0	0	0	0	(33,259)	20
21	Clerical & General Office Expenses	0	0	47,696	22,942	23,788	0	0	0	0	0	0	94,426	21
22	Employee Benefits & Payroll Taxes	0	0	61,755	0	(316)	0	0	0	0	0	0	61,439	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	18,482	0	0	0	0	0	0	0	0	18,482	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	50,276	196	0	0	0	0	0	0	0	0	50,472	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	(34,456)	56,151	(741,086)	22,942	23,472	0	0	(76)	0	0	0	(673,053)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(40,239)	56,151	(729,735)	13,983	22,881	41,556	0	(76)	0	0	0	(635,479)	29

STATE OF ILLINOIS **Summary B**

Facility Name & ID Number **Alden Northmoor Rehab & HCC** **#** **0041277** **Report Period Beginning:** **01/01/00** **Ending:** **12/31/00**

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	(8,939)	294,960	15,315	0	0	0	0	0	0	0	0	301,336	30
31	Amortization of Pre-Op. & Org.	0	3,060	0	0	0	0	4,949	0	0	0	0	8,009	31
32	Interest	(331)	714,067	6,478	0	0	0	8,191	0	0	0	0	728,405	32
33	Real Estate Taxes	0	434,918	8,011	0	0	0	0	0	0	0	0	442,929	33
34	Rent-Facility & Grounds	0	(1,552,513)	0	0	0	0	0	0	0	0	0	(1,552,513)	34
35	Rent-Equipment & Vehicles	0	0	25,335	0	0	0	0	0	0	0	0	25,335	35
36	Other (specify):*	0	54,509	0	0	0	0	0	0	0	0	0	54,509	36
37	**TOTAL Ownership**	(9,270)	(50,999)	55,139	0	0	0	13,140	0	0	0	0	8,010	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	(258,735)	0	0	(36,025)	(85,025)	0	(184,324)	0	0	0	0	(564,109)	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	(258,735)	0	0	(36,025)	(85,025)	0	(184,324)	0	0	0	0	(564,109)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(308,244)	5,152	(674,596)	(22,042)	(62,144)	41,556	(171,184)	(76)	0	0	0	(1,191,578)	45

Facility Name & ID Number Alden Northmoor Rehab & HCC # 0041277 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Alden Management Services, Inc.	100	see page 6k…		see pg 6k…		

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [x] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	34	rental income	$ 1,552,513	Northmoor Assoc.	0.00%	$	$ (1,552,513)	1
2	V	32	interest income	87,289	Northmoor Assoc.			(87,289)	2
3	V	33	real estate tax		Northmoor Assoc.		434,918	434,918	3
4	V	30	depreciation		Northmoor Assoc.		294,960	294,960	4
5	V	36	mortgage insurance		Northmoor Assoc.		54,509	54,509	5
6	V	26	general insurance		Northmoor Assoc.		50,276	50,276	6
7	V	31	amortization		Northmoor Assoc.		3,060	3,060	7
8	V	19	prof. Fees-accounting		Northmoor Assoc.		5,875	5,875	8
9	V	32	iod/lessee interest		Northmoor Assoc.		143,983	143,983	9
10	V	32	mortgage interest		Northmoor Assoc.		657,373	657,373	10
11	V								11
12	V								12
13	V								13
14	Total			$ 1,639,802			$ 1,644,954	$ * 5,152	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number Alden Northmoor Rehab & HCC # 0041277 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	6	maintenance/utilities	$	Alden Management Services, Inc.		$ 11,351	$ 11,351	15
16	V	19	professional fees	885,487	Alden Management Services, Inc.		15,555	(869,932)	16
17	V	20	licenses/fees		Alden Management Services, Inc.		717	717	17
18	V	21	gen'l & admin		Alden Management Services, Inc.		47,696	47,696	18
19	V	22	employee costs		Alden Management Services, Inc.		61,755	61,755	19
20	V	24	auto/seminar		Alden Management Services, Inc.		18,482	18,482	20
21	V	26	insurance		Alden Management Services, Inc.		196	196	21
22	V	30	depreciation		Alden Management Services, Inc.		15,315	15,315	22
23	V	32	interest		Alden Management Services, Inc.		6,478	6,478	23
24	V	33	real estate tax		Alden Management Services, Inc.		8,011	8,011	24
25	V	35	auto lease		Alden Management Services, Inc.		25,335	25,335	25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 885,487			$ 210,891	$ * (674,596)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number Alden Northmoor Rehab & HCC # 0041277 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
	Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V		2	tube feeding	$ 17,781	Pyramid Healthcare Services		$ 8,822	$ (8,959)	15
16	V		39	nursing supplies	6,375	Pyramid Healthcare Services		2,272	(4,103)	16
17	V		39	supplies / per diem fees	88,672	Pyramid Healthcare Services		56,750	(31,922)	17
18	V		21	gen'l admin		Pyramid Healthcare Services		22,942	22,942	18
19	V									19
20	V									20
21	V									21
22	V									22
23	V									23
24	V									24
25	V									25
26	V									26
27	V									27
28	V									28
29	V									29
30	V									30
31	V									31
32	V									32
33	V									33
34	V									34
35	V									35
36	V									36
37	V									37
38	V									38
39	Total				$ 112,828			$ 90,786	$ * (22,042)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number Alden Northmoor Rehab & HCC # 0041277 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	39	drugs	$ 297,233	Forum Extended Care II		$ 223,736	$ (73,497)	15
16	V	10	house stock	2,389	Forum Extended Care II		1,798	(591)	16
17	V	39	iv	46,620	Forum Extended Care II		35,092	(11,528)	17
18	V	22	vaccinations	1,276	Forum Extended Care II		960	(316)	18
19	V	21	gen'l & admin		Forum Extended Care II		23,788	23,788	19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 347,518			$ 285,374	$ * (62,144)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number Alden Northmoor Rehab & HCC # 0041277 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [x] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1 Schedule V	2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	3	housekeeping	$ 187,203	Tripoint Services	0.00%	$ 228,759	$ 41,556	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 187,203			$ 228,759	$ * 41,556	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number Alden Northmoor Rehab & HCC # 0041277 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1 Schedule V	2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	39	CPT REVENUES	$ 707,773	COMMUNITY PHYSICAL THERAPY	100.00%	$ 523,449	$ (184,324)	15
16	V	31	AMORTIZATION		COMMUNITY PHYSICAL THERAPY		4,949	4,949	16
17	V	32	INTEREST		COMMUNITY PHYSICAL THERAPY		8,191	8,191	17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 707,773			$ 536,589	$ * (171,184)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number Alden Northmoor Rehab & HCC # 0041277 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	19	Construction management fees	$ 5,358	Alden Bennett Construction	0.00%	$ 5,282	$ (76)	15
16	V	19	architectural/design fees	1,278	Alden Design Group		1,278		16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 6,636			$ 6,560	$ * (76)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number Alden Northmoor Rehab & HCC # 0041277 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week Hours	Percent	Compensation Included in Costs for this Reporting Period** Description	Amount	Schedule V. Line & Column Reference	
1	Floyd Schlossberg	President - AMS	CEO	100.00	180,375	2.89	7.24	SALARY	$ 14,071	21-1	1
2	Lauren Magnusson	Clinical Coordin.	nursing review	a.	69,100	2.89	7.24	SALARY	5,390	21-1	2
3	Terry Magnusson	Administrator/other	admini / mainten.	b.	71,401	2.89	7.24	SALARY	2,219	21-1	3
4	Audra Schlossberg-Elisco	Massage Therapist	massage therapy	c.	6,371	0.18	0.07	FEES	480	10a-3	4
5											5
6											6
7											7
8											8
9	a. Lauren is the daughter of Floyd Schlossberg and worked as a clinical coordinator for Alden Management Services in 2000.										9
10	b. Terry is the son-in-law of Floyd Schlossberg. He was the administrator of Alden Valley Ridge for 7 months and in construction/ misc. for 5 months in 2000.										10
11	c. Daughter of Floyd Schlossberg. Audra worked as a massage therapist for the year at various Alden facilities.										11
12											12
13								TOTAL	$ 22,160		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number Alden Northmoor Rehab & HCC # 0041277 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: ALDEN MANAGEMENT SERVICES, INC.
Street Address: 4200 W. PETERSON
City / State / Zip Code: CHICAGO, IL 60646
Phone Number: (773)286-3883
Fax Number: (773)286-3742

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1		SEE PAGE8A				$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number Alden Northmoor Rehab & HCC # 0041277 Report Period Beginning: 01/01/00 Ending: 12/31/00

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	WMF/PRUDENTIAL		X	MORTGAGE	$72,788.73	7/1/96	$ 9,194,900	$ 9,109,700	12/1/35	9.5000	$ 657,373	1
2												2
3												3
4	NM Corp-line of cr interest		x	Operations	none	1999			open	varies	103,648	4
5	Lessee Interest-NM Assoc.		x	Operations	none	1998	69,928	69,928	open	varies	7,957	5
	Working Capital											
6	IOD loan-WMF/Prudent.		x	OPERATIONS	$12,958.00	12/1/99	1,941,500	1,924,942		VARIES	136,026	6
7	RELATED PARTY	x		OPERATIONS	NONE					VARIES	6,478	7
8	RELATED PARTY-CPT	x		OPERATIONS	NONE					VARIES	8,191	8
9	TOTAL Facility Related				$85,746.73		$ 11,206,328	$ 11,104,570			$ 919,673	9
	B. Non-Facility Related*											
10	NM Corp-Interest income		x	offset interest expense with interest income							(145)	10
11	NM Assoc-interest income(4010/11)		x	offset interest expense with interest income							(87,289)	11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$ (87,434)	14
15	TOTALS (line 9+line14)						$ 11,206,328	$ 11,104,570			$ 832,239	15

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number Alden Northmoor Rehab & HCC # 0041277 **Report Period Beginning:** 01/01/00 **Ending:** 12/31/00

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 1999 report.	$	460,000	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$	437,918	2
3. Under or (over) accrual (line 2 minus line 1).	$	(22,082)	3
4. Real Estate Tax accrual used for 2000 report. (Detail and explain your calculation of this accrual on the lines below.)	$	457,000	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**	$		5
6. Subtract a refund of real estate taxes used previously to calculate a payment rate. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For 19 Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$	434,918	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
1995	NONE	8
1996	359,526	9
1997	429,651	10
1998	437,278	11
1999	437,918	12

LINE4: 2000 ACCRUAL BASED ON 4.5% INCREASE OF PRIOR YEAR BILL: $437,918X1.045=457,000.

FOR OHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 1999	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

Facility Name & ID Number Alden Northmoor Rehab & HCC # 0041277 Report Period Beginning: 01/01/00 Ending: 12/31/00

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 83,872 B. General Construction Type: Exterior BRICK Frame STEEL Number of Stories 4

C. Does the Operating Entity? [ ] (a) Own the Facility [X] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [ ] (a) Own the Equipment [X] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [X] YES [ ] NO
If so, please complete the following:

1. Total Amount Incurred: 29,847
2. Number of Years Over Which it is Being Amortized: 5
3. Current Period Amortization: 3,060
4. Dates Incurred: 1994-1999

Nature of Costs: LEGAL & ACCOUNTING FEES REGARDING FORMATION OF PARTNERSHIP
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	NURSING HOME	53,009		$ 1,429,683	1
2					2
3	TOTALS	53,009		$ 1,429,683	3

Facility Name & ID Number Alden Northmoor Rehab & HCC # 0041277 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	198			1994	$ 8,796,651	$ 228,856	40	$ 219,916	$ (8,939)	$ 1,082,230	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	CABLE INSTALLATION			1996	5,704	1,141	5	1,141		5,039	9
10	CABLE INSTALLATION			1996	3,286	657	5	657		2,738	10
11	FIRE ALARM			1996	17,753	1,184	15	1,184		5,030	11
12	INSTALL ADDITIONAL OUTLETS			1997	2,108	211	10	211		826	12
13	INSTALL ADDITIONAL OUTLETS			1997	1,116	112	10	112		437	13
14	INSTALL ADDITIONAL OUTLETS			1997	2,668	267	10	267		1,067	14
15	ACCESS CONTROL MATERIALS			1997	4,714	471	10	471		1,532	15
16	HVAC REPAIR			1997	6,413	1,283	5	1,283		4,382	16
17	PHONE LINE INSTALLATION			1997	2,768	554	5	554		1,891	17
18	PHONE LINE INSTALLATION			1997	3,096	619	5	619		1,909	18
19	EQUIPMENT FOR SECURITY SYSTEM			1998	4,170	417	10	417		1,251	19
20	CHANGE BELT ON FANS & AIRHANDLERS			1998	2,012	402	5	402		1,107	20
21	WIRE THIRD FLOOR & TWENTY BED JACKS			1998	7,189	719	10	719		1,977	21
22	REPAIR PUMP MOTOR ON ELEVATOR			1998	3,500	175	20	175		437	22
23	INSTALL PUMP MOTOR ON DISHWASHER			1998	2,029	203	10	203		524	23
24	INSTALL DOOR LOCKS			1998	8,157	816	10	816		2,311	24
25	DOOR SYSTEM WORK			1998	775	78	10	78		168	25
26	REPAIR NURSE CALL SYSTEM			1998	275	28	10	28		60	26
27	REPAIR NURSE CALL SYSTEM			1998	1,032	103	10	103		224	27
28	REPAIR NURSE CALL SYSTEM			1998	982	98	10	98		213	28
29	CHILLERS			1998	52,667	3,511	15	3,511		7,315	29
30	COMPUTER & TRAINING & INSTALLATION			1998	3,158	632	5	632		1,842	30
31	CANOPY CONSTRUCTION			1998	73,120	4,875	15	4,875		13,405	31
32	CONTINUE ON PAGE 12A …										32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$ 9,005,342	$ 247,409		$ 238,469	$ (8,939)	$ 1,137,915	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Alden Northmoor Rehab & HCC # 0041277 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Climate Service (replace compressor)			1999	2,603	174	15	174		347	9
10	Washtown Equipment (dryer, installation)			1999	2,875	288	10	288		503	10
11	Climate Service(repair chiller pump)			1999	2,940	588	5	588		882	11
12	Equipment INT (dryer repair)			1999	130	26	5	26		39	12
13	Rykoff Sexton(coffee machine)			1999	2,021	404	5	404		573	13
14	Equipment INT (dryer repair)			1999	1,891	378	5	378		504	14
15	Climate Service(chiller maintenance)			1999	3,071	614	5	614		768	15
16	United Communications Group(phone repair)			1999	1,593	159	10	159		186	16
17	**Long Elevator(elevator maintenance)			1999	2,168	108	20	108		126	17
18	Climate Service(ice machine repair)			1999	1,885	189	10	189		204	18
19	Climate Service(condensor repair)			1999	3,579	239	15	239		318	19
20	ABC-misc construction work			2000	16,003	133	10	133		133	20
21	CSI-change exhaust belt-hvac			2000	1,695	339	5	339		339	21
22	ABC-metal frame/heating vent			2000	2,048	85	20	85		85	22
23	ABC-misc construction work			2000	2,059	69	5	69		69	23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$ 46,561	$ 3,793		$ 3,793	$	$ 5,077	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Alden Northmoor Rehab & HCC # 0041277 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	Related			1978	$ 12,184	$ 554	22	$ 554	$	$ 11,565	4
5	Party			1978	5,953	271	32	271		4,767	5
6	(Forum)										6
7											7
8											8
	Improvement Type**										
9	Related Party - AMS:										9
10	Leasehold Improvement - Remodeling			1993	5,378	223	various	223		115,184	10
11	Leasehold Improvement - Remodeling			1994	2,663	407	various	407		55,299	11
12											12
13	Related Party - Forum:										13
14	Leasehold Improvement - Remodeling			1980	19,102	955	20	955		19,102	14
15	Leasehold Improvement - Remodeling			1980	113		10			113	15
16	Leasehold Improvement - Remodeling			1986	32		6			32	16
17	Leasehold Improvement - Remodeling			1990	51		5			51	17
18	Leasehold Improvement - Remodeling			1991	12		5			12	18
19	Leasehold Improvement - Remodeling			1993	4,085	408	10	408		4,085	19
20	Leasehold Improvement - Remodeling			1993	3,199	330	9.7	330		3,058	20
21	Leasehold Improvement - SIGN			1994	258	21	10	21		145	21
22	Leasehold Improvement - DRYVIT			1994	437	44	12	44		244	22
23	Leasehold Improvement - NEW AC			1995	714	48	10	48		71	23
24	Leasehold Improvement - Roof			1997	961	51	10	51		760	24
25	Leasehold Improvement - Roof			1998	853	57	10	57		369	25
26	Leasehold Improvements-Roof			1985	809	54	19	54		175	26
27	Leasehold Improvements-Roof			1999	1,373	92	15	92		198	27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$ 58,177	$ 3,514		$ 3,514	$	$ 215,231	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Alden Northmoor Rehab & HCC # 0041277 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
37	Purchased in Prior Years	$ 1,139,181	$ 83,357	$ 83,357	$	varies	$ 381,181	37
38	Current Year Purchases	30,344	2,907	2,907		varies	2,907	38
39	Fully Depreciated Assets	20,651	1,214	1,214		varies	20,651	39
40								40
41	TOTALS	$ 1,190,176	$ 87,478	$ 87,478	$		$ 404,739	41

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
42	various	busses, van, engine	1998-2000	$ 26,682	$ 2,494	$ 2,494	$	3	$ 3,030	42
43		1998-2000								43
44										44
45										45
46	TOTALS			$ 26,682	$ 2,494	$ 2,494	$		$ 3,030	46

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
47	Total Historical Cost	(line 3,col.4 + line 36,col.4 + line 41,col.1 + line 46,col.4)	$ 11,756,622	47
48	Current Book Depreciation	(line 36,col.5 + line 41,col.2 + line 46,col.5)	$ 344,688	48
49	Straight Line Depreciation	(line 36,col.7 + line 41,col.3 + line 46,col.6)	$ 335,749	49 **
50	Adjustments	(line 36,col.8 + line 41,col.4 + line 46,col.7)	$ (8,939)	50
51	Accumulated Depreciation	(line 36,col.9 + line 41,col.6 + line 46,col.9)	$ 1,765,992	51

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
52		$	$	$	52
53					53
54					54
55					55
56					56
57	TOTALS	$	$	$	57

G. Construction-in-Progress

	Description	Cost	
58		$	58
59			59
60			60
61		$	61

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number Alden Northmoor Rehab & HCC # 0041277 Report Period Beginning: 01/01/00 Ending: 12/31/00

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: NOTHMOOR ASSOCIATES - RELATED PARTY

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. [ ] YES [X] NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized by the length of the lease .

9. Option to Buy: [ ] YES [X] NO Terms: *

10. Effective dates of current rental agreement:
Beginning 4/1/1996
Ending 3/31/2006

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	12/31/01	$ 1564K
13.	12/31/02	$ 1564K
14.	12/31/03	$ 1564K

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? [ ] YES [X] NO

16. Rental Amount for movable equipment: $ 8,872 Description: COPY MACHINE LEASE
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	Related Party		$	$	17
18	see page 8A		21110	25,335	18
19					19
20					20
21	TOTAL		$ 2111	$ 25,335	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number Alden Northmoor Rehab & HCC # 0041277 Report Period Beginning: 01/01/00 Ending: 12/31/00

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? [ ] YES [X] NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

SKILLED NURSING IS ALREADY ON SITE

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER AIDE ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$ NA

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

Facility Name & ID Number Alden Northmoor Rehab & HCC # 0041277 Report Period Beginning: 01/01/00 Ending: 12/31/00

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	39-3	hrs	$		$ 284,968	$ 0		$ 284,968	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			89,661			89,661	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			337,744			337,744	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	see page 16A…	# of prescrpts				212,208		212,208	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):	see page 16A…					(29,280)		(29,280)	13
14	TOTAL			$		$ 712,373	$ 182,928		$ 895,301	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

STATE OF ILLINOIS

Facility Name & ID Number Alden Northmoor Rehab & HCC # 0041277 **Report Period Beginning:** 01/01/00 **Ending:** 12/31/00

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/00 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 229,784	$ 229,784	1
2	Cash-Patient Deposits	22,774	22,774	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance (17,027))	2,280,598	2,280,598	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	49,003	141,936	6
7	Other Prepaid Expenses	1,660	29,896	7
8	Accounts Receivable (owners or related parties)	407,229	788,705	8
9	Other(specify): misc. receiv /other escrows	445,819	694,555	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 3,436,868	$ 4,188,249	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		1,429,683	13
14	Buildings, at Historical Cost		9,095,842	14
15	Leasehold Improvements, at Historical Cost	286,782	286,782	15
16	Equipment, at Historical Cost	104,639	1,120,088	16
17	Accumulated Depreciation (book methods)	(119,344)	(1,521,555)	17
18	Deferred Charges		6,596	18
19	Organization & Pre-Operating Costs		522,704	19
20	Accumulated Amortization - Organization & Pre-Operating Costs		(28,365)	20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 272,077	$ 10,911,775	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 3,708,944	$ 15,100,024	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 3,087,599	$ 1,964,812	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	32,087	32,087	28
29	Short-Term Notes Payable		48,000	29
30	Accrued Salaries Payable	267,728	267,728	30
31	Accrued Taxes Payable (excluding real estate taxes)	101,099	101,099	31
32	Accrued Real Estate Taxes(Sch.IX-B)		457,000	32
33	Accrued Interest Payable		65,967	33
34	Deferred Compensation			34
35	Federal and State Income Taxes	(1,065,768)	(1,065,768)	35
	Other Current Liabilities(specify):			
36	third party	246,395	393,680	36
37	other accr exps		433,776	37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 2,669,139	$ 2,698,381	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable		1,924,943	39
40	Mortgage Payable		9,061,700	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$ 10,986,643	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 2,669,139	$ 13,685,024	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 1,039,804	$ 1,415,001	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 3,708,944	$ 15,100,024	48

***(See instructions.)**

Facility Name & ID Number Alden Northmoor Rehab & HCC # 0041277 Report Period Beginning: 01/01/00 Ending: 12/31/00

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (92,362)	1
2	Restatements (describe):		2
3	**External auditor's adjustments made after 1999 cost report**		3
4	**was filed. The adjustments had no effect on reimbursable**		4
5	**cost: bad debt expense and mediacre revenues were adjusted:**	151,350	5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 58,988	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	980,816	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 980,816	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 1,039,804	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number Alden Northmoor Rehab & HCC # 0041277 Report Period Beginning: 01/01/00 Ending: 12/31/00

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 10,385,467	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 10,385,467	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	170,138	6
7	Oxygen	24,079	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 194,217	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	1,835	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	7,075	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	197,792	21
22	Laundry	4,725	22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 211,427	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	163	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 163	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Adj's made to prior year expenses. Since prior year reports		28
28a	were not used, we've made no offsetting adjs on pg 5 or 5a	10,229	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 10,229	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 10,801,502	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,858,873	31
32	Health Care	2,903,589	32
33	General Administration	1,790,175	33
	B. Capital Expense		
34	Ownership	1,699,937	34
	C. Ancillary Expense		
35	Special Cost Centers	1,459,410	35
36	Provider Participation Fee	108,702	36
	D. Other Expenses (specify):		
37	Note: this will not balance to page 3 & 4 due to related party		37
38	amounts entered to pgs 3 & 4…		38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 9,820,686	40
41	**Income before Income Taxes (line 30 minus line 40)****	980,816	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 980,816	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? not yet done If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

**** **Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number Alden Northmoor Rehab & HCC # 0041277 Report Period Beginning: 01/01/00 Ending: 12/31/00

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	2,904	3,216	$ 65,491	$ 20.36	1
2	Assistant Director of Nursing	2,112	2,275	60,185	26.45	2
3	Registered Nurses	37,016	40,141	901,270	22.45	3
4	Licensed Practical Nurses	13,404	14,413	273,088	18.95	4
5	Nurse Aides & Orderlies	114,507	118,599	1,176,852	9.92	5
6	Nurse Aide Trainees					6
7	Licensed Therapist	1,778	1,827	17,707	9.69	7
8	Rehab/Therapy Aides					8
9	Activity Director	3,664	3,824	80,057	20.94	9
10	Activity Assistants	12,084	12,734	138,284	10.86	10
11	Social Service Workers	2,604	2,800	47,979	17.14	11
12	Dietician	19,296	20,315	200,666	9.88	12
13	Food Service Supervisor	200	200	3,360	16.80	13
14	Head Cook	13,884	14,363	165,196	11.50	14
15	Cook Helpers/Assistants	12,844	13,311	128,162	9.63	15
16	Dishwashers					16
17	Maintenance Workers	2,592	2,920	47,486	16.26	17
18	Housekeepers	2,143	2,234	27,198	12.17	18
19	Laundry	9,880	10,551	83,838	7.95	19
20	Administrator					20
21	Assistant Administrator					21
22	Other Administrative	6,016	6,400	126,630	19.79	22
23	Office Manager	6,548	6,801	59,826	8.80	23
24	Clerical					24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator	1,788	2,084	51,262	24.60	29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify) Clinical Suup. Sup	947	993	53,873	54.25	33
34	TOTAL (lines 1 - 33)	266,211	280,001	$ 3,708,410 *	$ 13.24	34

* This total must agree with page 4, column 1, line 45. ** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant		$		35
36	Medical Director				36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	48	2,472	11-3	44
45	Social Service Consultant	20	1,030	12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	68	$ 3,502		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses				51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)		$		53

Facility Name & ID Number Alden Northmoor Rehab & HCC # 0041277 Report Period Beginning: 01/01/00 Ending: 12/31/00

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
ROSLYN AGPASA	ADMINISTRATOR		$ 34,633
OLIVER UMADHAY	ADMINISTRATOR		34,400
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 69,033

B. Administrative - Other

Description	Amount
	$
TOTAL (agree to Schedule V, line 17, col. 3)	$
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
ALDEN MANAGEMENT SVS	MGMT. FEES	$ 885,487
BLACKMAN KALLICK	ACCOUNTING	11,400
KENNETH F. /B. GREENBURG H.	LEGAL	28,709
AUDRA SCHLOSSBERG **	massage therapy **	480
VARIOUS PRO. FEES	PRO. FEES	1,402
US GAS & ENERGY	UTILITY CONSULT	725
ALDEN DESIGN	DESIGN FEES	1,278
ALDEN BENNET CONSTRUCTIO	CONS. FEES	5,358
** reclassed to ln 10a on pg 3		
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 934,839

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 46,768
Unemployment Compensation Insurance	29,266
FICA Taxes	278,105
Employee Health Insurance	48,346
Employee Meals	37,538
Illinois Municipal Retirement Fund (IMRF)*	
Chicago head tax	6,364
RELATED PARTY	61,439
UNION HEALTH & WELFARE INSURANCE	42,644
DENTAL / LIFE INSURANCE	400
EMP. RELATIONS /EMP. VACC	1,950
PAYROLL MISC. COST / TUITION REIMB	483
PENSION / 401K MATCH	24,725
TOTAL (agree to Schedule V, line 22, col.8)	$ 578,027

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	1,553
Health Care Worker Background Check	
(Indicate # of checks performed 2)	28
Misc. Subscriptions (IHCA and others)	10,027
City of Chicago License	1,000
Related Party	717
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 13,325

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
AUTO & TRAVEL	156
Seminar Expense	
SEMINARS	606
Related Party	18,482
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 19,244

**See instructions.

Facility Name & ID Number Alden Northmoor Rehab & HCC # 0041277 Report Period Beginning: 01/01/00 Ending: 12/31/00

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1997	FY1998	FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005
1	INSTALL BELTS ON A/C	MAY-97	$ 2,367	3	$ 526	$ 789	$ 789	$ 263	$ 0	$	$	$	$
2	REPAIR AIR COMPRES	OCT-97	3,174	3	264	1,058	1,058	794	0				
3	REPAIR MOTOR,VENT	NOV-97	3,140	3	174	1,047	1,047	872	0				
4	HVAC REPAIR	JUN-98	2,661	3		517	887	887	370	0			
5	INSTALL CONTROLS	JUL-98	3,900	3		650	1,300	1,300	650	0			
6	INSTL PHASE MONITO	JUL-98	4,250	3		708	1,417	1,417	708	0			
7	REPLACE COOLING FA	DEC-98	1,219	3		34	406	406	372	0			
8	REPAIR FAN FREQUEN	DEC-98	446	3		12	149	149	136	0			
9	Climate Serv.-to aj.'98	dec'98	(446)	3			(161)	(149)	(136)	0			
10	painting ytd>1,500 1999	7/99	6,870	3			1,145	2,290	2,290	1,145	0		
11	ABC(misc. construc. Job)	7/00	3,677	3				613	1,226	1,226	612	0	
12	ABC(repair carpet)	9/00	2,042	3				227	681	681	453	0	
13	ABC(misc. construc. Job)	11/00	5,101	3				283	1,700	1,700	1,418	0	
14	painting ytd>1,500 2000	7/00	5,943	3				990	1,981	1,981	990	0	
15													
16													
17													
18													
19													
20	TOTALS		$ 44,343		$ 964	$ 4,815	$ 8,037	$ 10,342	$ 9,978	$ 6,733	$ 3,473	$	$

Facility Name & ID Number Alden Northmoor Rehab & HCC # 0041277 Report Period Beginning: 01/01/00 Ending: 12/31/00

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **YES**

(2) Are there any dues to nursing home associations included on the cost report? If YES, give association name and amount. **Illinois Healthcare Assoc. $ 10,027**

(3) Did the nursing home make political contributions or payments to a political action organization? **YES** If YES, have these costs been properly adjusted out of the cost report? **YES**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **NO** If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? **YES** What was the average life used for new equipment added during this period? **6.5 YEARS**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **11,995** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **YES** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **NO** If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **108,702** This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **NO** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **YES**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **NO** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **37,538** Has any meal income been offset against related costs? **NONE** Indicate the amount. $ **N/A**

(16) Travel and Transportation

a. Are there costs included for out-of-state travel? **NO** If YES, attach a complete explanation.

b. Do you have a separate contract with the Department to provide medical transportation for residents? **NO** If YES, please indicate the amount of income earned from such a program during this reporting period. $ **N/A**

c. What percent of all travel expense relates to transportation of nurses and patients?

d. Have vehicle usage logs been maintained? **N/A**

e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **NO**

f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **N/A**

g. Does the facility transport residents to and from day training? NO Indicate the amount of income earned from providing such transportation during this reporting period. $

(17) Has an audit been performed by an independent certified public accounting firm? **YES** Firm Name: **Blackman Kallick Barlestein** The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? **NO** If no, please explain. **NOT YET COMPLETED**

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? **YES**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **YES** Attach invoices and a summary of services for all architect and appraisal fees.